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Motivational interviewing: Experiences of primary care nurses trained in the method

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ABSTRACT

Motivational interviewing is a person-centered counseling style used to promote behavioral change regarding a wide variety of lifestyle problems. Use of motivational interview is growing worldwide and among many different healthcare professions, including primary care nursing. The study aim was to describe motivational interview trained nurses' experiences of motivational interviewing in primary care settings. The study had a qualitative descriptive design. It was carried out in Swedish primary care settings in two county council districts, with 20 primary care nurses trained in motivational interviewing. Half of them used the method in their work, half did not. Qualitative semi-structured interviews were used. Data were analyzed using qualitative content analysis. The nurses experienced that openness to the approach and an encouraging working climate are required to overcome internal resistance and to increase use of motivational interviewing. They also experienced mutual benefit: motivational interviewing elicits and develops abilities in both nurses and patients. For the nurses using it, motivational interviewing is perceived to facilitate work with patients in need of lifestyle change. Lack of training/education, support, interest and appropriate work tasks/patients are reasons for not using motivational interviewing.

Introduction

Motivational interviewing (MI) is a person-centered conversation style intended to promote behavioral change regarding a wide variety of lifestyle problems. Use of MI is growing worldwide and among many different health-care professions (Lundahl and Burke, 2009; Madson et al., 2009), including primary care nursing (Soderlund et al., 2011).

Noncommunicable diseases (NCDs) are the cause of the greatest proportion of deaths globally (63%). About 38% of people dying of NCDs die too young, between 30 and 70 years of age. Most of the NCDs and deaths due to NCDs are preventable through reduction of their common behavioral risk factors, especially, tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol. The four main NCDs are cardiovascular diseases, cancers, diabetes and chronic lung diseases (World Health Organization (WHO), 2013).

Health promotion and disease prevention are elementary parts of nurses' work in primary care (WHO Europe, 2006; WHO, 1978). Nurses see a large number of patients and thus play an important role in identifying at-risk patients (The Swedish Board of Health and Welfare (SBHW), 2011; WHO, 2010) and in motivating them to pursue a healthier lifestyle (Lambe and Collins, 2010).

Outcomes following lifestyle change recommendations for patients have been poor (Magkos et al., 2009). Traditional interventions, such as an expert providing advice, have been shown to be ineffective (Emmons and Rollnick, 2001), and patients are commonly resistant to a confrontational approach (Boardman et al., 2006). The main barriers to achieving success with traditional lifestyle counseling in primary care settings are: time limitations owing to heavy workloads, patient resistance, lack of training, knowledge, and funding for prevention as well as the fact that the main focus is on treatment (Lambe and Collins, 2010). Primary care nurses have felt powerless when patients have not followed their advice, and the nurses themselves have not understood patients' difficulty in making changes (Jansink et al., 2010). For this reason,

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researchers have found it important to implement a new well-used method (Lundahl and Burke, 2009; Madson et al., 2009) to help patients during the conversational and motivational process.

Guidelines for disease prevention (National Institute for Health and Clinical Excellence, 2006; SBHW, 2011; U.S. Department of Health and Human Services (2011); WHO, 2010) suggest methods to support changes in lifestyle habits that cause a large proportion of the world's major diseases. The foundation for all measures suggested in the guidelines is some kind of counseling or conversation, for example MI (WHO, 2010; SBHW, 2011). Because national and international guidelines have been developed suggesting motivational interviewing, training in the method is recommended for healthcare personnel and use of the method has grown worldwide. About two thirds of nurses, midwifes and physicians in the Swedish primary care system have been trained in MI (The Swedish Institute of Public Health, 2010). Training in motivational interviewing usually lasts 1–4 days. The content of training includes: introduction to and demonstration of the method and guided practice in the communication techniques (MINT-Nordic, 2011).

Motivational interviewing has been shown to be effective in changing lifestyle behavior, particularly regarding substance use, but also health behaviors in general as well as management of chronic conditions (Lundahl et al., 2013; Martins and McNeil, 2009; Purath et al., 2014; Rubak et al., 2005). It is a collaborative goal-oriented style of communication intended to elicit and strengthen an individual's own reasons, motivation and commitment to change. Motivational interviewing represents an integration of special clinical skills intended to promote motivation for change; it is a way of being with people. The role of counselors/providers of MI (e.g., physicians, nurses or therapists) is to support, encourage and direct the client in exploring, resolving ambivalence and enhancing motivation (Miller and Rollnick, 2013). The fundamental approach or the spirit of motivational interviewing is to collaborate with the individual, accept what he/she brings to the situation, show respect for his/her autonomy, show empathy with and affirmation of the client. The spirit of motivational interviewing also involves compassion and evocation of change. Motivational interviewing is done for and with an individual. Practicing motivational interviewing involves the use of five central communication skills: ask open-ended questions, listen reflectively, affirm, summarize and inform/give advice with permission (Miller and Rollnick, 2013).

A systematic review (Soderlund et al., 2011) of training in motivational interviewing for general healthcare practitioners showed that seven of ten reviewed studies have also investigated, in addition to outcomes of MI (competence in MI and patient health), different aspects of clinical use after training. None of these seven studies included nurses in primary care. The reviewed studies revealed that healthcare professionals reported lack of time, patient resistance and difficulty learning new methods as barriers to clinical use of MI. They also reported that MI was relevant and more effective than traditional advice giving. Use of MI in Swedish primary care settings is relatively new, and studies describing primary care nurses' experiences of the method are few. One study examining this in a Swedish context, among nurses who use MI, is Brobeck et al. (2011), who showed that MI places demands on nurses and that nurses working with the method need to make an effort to embody it. According to a survey study in primary care setting in Sweden, less than half of the primary care nurses trained in motivational interviewing used it (Östlund et al., 2014). Given the growing use of motivational interviewing and the costs of training, it is of critical importance to further investigate experiences of the method among primary care nurses trained in it. Moreover, to get a more complete picture, it is important to include nurses no longer using the method and to investigate their experiences of it, prerequisites for using it and reasons for not using it, the goal being to develop training in and use of motivational interviewing in primary care settings.

Aim

The aim of the study was to describe experiences of motivational interviewing among primary care nurses trained in the method.

Methods

The study had a qualitative descriptive design, which was considered the best method for describing the nurses' experiences. The goal of qualitative studies is to increase our understanding of a phenomenon as it exists in reality (Polit and Beck, 2012).

Settings

The study was carried out in Swedish primary care settings with nurses working at 18 different primary care centers in two county council districts. The included counties represented both larger towns and rural areas with small communities, a population of 614,760 (Statistics Sweden (SCB), 2011a) and approximately 800 primary care nurses. In Sweden, there are 20 county council districts responsible for healthcare. Primary care is the foundation of health and medical care, and residents are to turn to primary care centers with their health problems. Primary care and primary care nurses also work with health promotion. About 93,600 individuals visit Swedish primary care centers each day (excluding visits to physicians) (Swedish Association of Local Authorities and Regions, 2013). The offered training in motivational interviewing varies from two-to four-day short courses arranged by the county councils to university courses lasting for several weeks. The primary care nurses had all encountered patients with lifestyle problems in the context of their different specialized areas, which included child health, diabetes, asthma, blood pressure care, health sessions, quit-smoking sessions and telephone advice.

Participants

Purposive sampling was used to select primary care nurses trained in MI. The primary care nurses in the study will henceforth be referred to as nurses. The nurses were selected to ensure variation in age, gender, work task/type of office, urban and rural locations as well as use of MI, thus increasing the likelihood of different experiences and descriptions being represented in the interview data (Petersen et al., 2009; Polit and Beck, 2012). The mean age of the participating nurses was 51.0 years (SD ± 9.7). One of them was a man. They had worked as nurses for a mean of 24.8 years (SD ± 11.8). They had undergone training in MI lasting for a mean of 4.6 days. Half of the sample used the method in their work and half did not, according to self-reports. Four of the nurses who reported not using MI had used it immediately after training, but no longer did so. The remaining six had never used it after training. The nurses who reported using MI had worked with the method for a mean of 5.4 years. The nurses' characteristics are presented in Table 1.

Procedure and data collection

Data were collected using semi-structured interviews, all conducted by the first author. The author contacted the local authorities at each healthcare center to obtain information on nurses who